MALETTA PFEIFFER & ASSOCIATES

Workers Compensation & Motor Vehicle Accident

Claim# ______________________________

Date of Injury/Accident: ______________________________

Date of Surgery: ______________________________

Workers Compensation Insurance Carrier: ______________________________

Adjuster Name: ______________________________

Adjuster Phone Number: ______________________________

Adjuster Email: ______________________________

Motor Vehicle Insurance: ______________________________

Med-Pay on Policy **YES / NO**

If YES,

Insurance Carrier: ______________________________

Insurance Contact: ______________________________

Ins. Contact Phone Number: ______________________________

Med-Pay Amount: ______________________________

Employer: ______________________________

Employer Address: ______________________________

Employer Phone Number: ______________________________

Are you still employed: **YES / NO**

Are you still working: **YES / NO**

Attorney Name: ______________________________

Attorney Phone Number: ______________________________

Signature:______________________________ **Date:**__________